



modivcare

VA Operations  
Exceptions Department  
798 Park Ave NW  
Norton, VA 24273  
PHONE: 866.679.6330  
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**Level of Service Certification of Medical Necessity for Non-Emergency  
Ambulance, Stretcher and Wheel Chair Transport**

In an effort to insure every member is transported by the most appropriate means necessary, Modivcare may require completion of this form. If requested, please certify the level of service needed and fax to the number shown above.

Patient Information				Provider Information	
DOB: _____ / ____ / ____	Sex M F	Age	Medicaid ID #	Medicaid Provider #	Phone # ( )
Patient Name (Last, First, MI)				Provider Name & Address	
<b>LEVEL OF SERVICE REQUIRED BY MEMBER &amp; PRESCRIBED BY MEDICAL PROVIDER</b>					
<u>Stretcher Transport</u>			<u>Wheelchair Transport</u>		
Stretcher/Ambulance <input type="checkbox"/> Stretcher Van <input type="checkbox"/>			Manual <input type="checkbox"/> Electric <input type="checkbox"/> Width of Chair _____		
Stretcher Van Transport is provided only for Members who do not require medical assistance during transport but are non-ambulatory and unable to use a wheelchair. Members using wheelchairs who also require medical assistance during transport should be referred to the appropriate level of ambulance transport.					
<b>Medical Equipment Needed</b>		<b>Medical Necessity Criteria</b>		<b>Medical Necessity Criteria (Cont.)</b>	
___ Airway Monitoring and/or Suctioning ___ Oxygen ___ Ventilator Dependent ___ Other _____		___ Bed-Confined ___ History of existing paralysis/CA ___ Decubitus Ulcers/Cannot Sit Safely ___ Hip/Leg/Back Precautions/Cannot Sit Safely		___ Contractures ___ Confused/Lethargic/Comatose ___ Cannot Support self while seated in a wheelchair for transport distance ___ Other _____	
Summary of Member's medical history establishing the medical necessity for the prescribed level of service: (Additional documentation may be attached when necessary.)					
Estimated Duration of This Level of Service. Check One      60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> Ongoing <input type="checkbox"/>					
Knowingly providing false information on this Certification may constitute fraud and may prevent the Member from receiving further transportation services. If you have any questions please contact Modivcare's Facility Assistance Department at <b>866-679-6330</b>  <i>I certify that to the best of my knowledge, the above information is true, accurate and complete and the level of service required for the Member's transport is medically necessary for the Member's health.</i>					
<b>NAME:</b> _____		<b>SIGNATURE:</b> _____		<b>DATE:</b> _____	
This Certification may be completed and signed only by the Member's attending physician, physician's assistant or RN to confirm a medically necessary level of service. Please complete form and fax to (866) 885-3788.					